TRUST BOARD IN PUBLIC	Date: 27th November 2012 Agenda Item:
REPORT TITLE:	**Board Assurance Framework**
EXECUTIVE SPONSOR:	Gillian Francis-Musanu Director of Corporate Affairs
REPORT AUTHOR:	Colin Pink Acting Head of Integrated Governance and Quality
REPORT DISCUSSED PREVIOUSLY: (name of sub-committee/group & date)	Executive Team Meeting (13/03/13)

Purpose of the Report and Action Required:		**(√)**
The Board Assurance Framework (BAF) describes the principal risks that relate to the organisation's strategic objectives and priorities. It is intended to provide assurances to the Board in relation to the management of risks that threaten the ability of the organisation to achieve these objectives.	**Approval**	
	Discussion	√
	Information/Assurance	√

Summary: (Key Issues)

The BAF highlights 24 potential risks to the trusts strategic objectives.

The Board is asked to note the current updated report and consider the following:

- Does the board agree with the existing controls and assurances
- Are the mitigating actions acceptable for the target risk score.

Relationship to Trust Corporate Objectives & Assurance Framework:

This report is the main document that reviews the Trust Corporate Objectives and is the Assurance Framework.

Corporate Impact Assessment:	
Legal and regulatory implications	The report is a requirement for all NHS organisations.
Financial implications	As discussed in sections 4.1a – 4.1b (Income generation linked to activity referred to throughout the document)
Patient Experience/Engagement	Patient experience and engagement is one of the Trusts strategic objectives. .
Risk & Performance Management	These are highlighted throughout the report.
NHS Constitution/Equality & Diversity/Communication	Discussed throughout the report but with the greatest detail in objective 2.

Attachments:

Board Assurance Framework spreadsheet.

TRUST BOARD REPORT – 28TH MARCH 2013
BOARD ASSURANCE FRAMEWORK

1. Introduction

The Board Assurance Framework (BAF) describes the principal risks that relate to the organisation's strategic objectives and priorities. It is intended to provide assurances to the Board in relation to the management of risks that threaten the ability of the organisation to achieve these objectives.

The Trust has identified four main objectives:

1) Deliver safe, high quality, coordinated care
2) Ensure patients are cared for and cared about
3) Work in partnership with our community
4) Become a sustainable, effective organisation

These objectives are broken down into specific areas and the BAF details the key risks that the Trust faces to the delivery of these priorities, the controls that are in place, the sources and effects of assurance and mitigating actions to reduce the likelihood of the impact of the risk materialising. (Some priorities have more than one associated risk)

2. Current status

The BAF (attached) details a total of 24 significant risks to the four Trust objectives (9 risks for objectives 1 and 4; and 3 risks for objectives 2 and 3).

Objective	Red (15-25)	Amber (8-12)	Green (1-6)
1. Deliver safe, high quality, coordinated care	0	6	3
2. Ensure patients are cared for and cared about	0	3	0
3. Work in partnership with our community	0	2	1
4. Become a sustainable, effective organisation	2	4	3
Total	**2**	**15**	**7**

The objective of the BAF is to ensure that all risks are mitigated to an appropriate or acceptable level. It is expected that not all risks will be able to have mitigating controls that reduce the risk to green (low impact, low likelihood).

All risks have been reviewed by an appropriate member of the executive team. The risks identified in the BAF are being aligned with those on the Trust Risk Register.

3. Key risks Identified

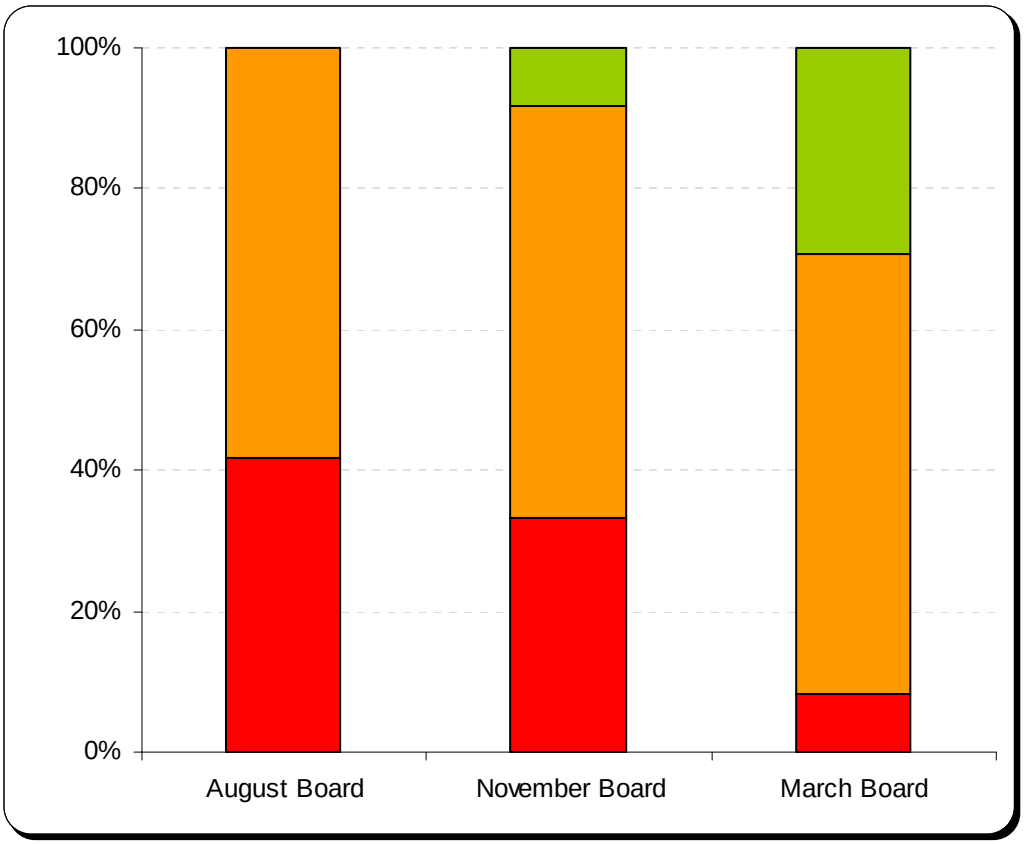
The BAF highlights the following 2 key risks to the Trust objectives that have been identified at time of updating the framework. These are:

i) 4.1c: To produce realistic medium term financial plan (risk to objective 4).

ii) 4.1d: Liquidity and subsequent payment issues (risk to Objective 4).

4. Changes throughout financial year

Grading	August Board	November Board	March Board
Red	10	8	2
Amber	14	14	15
Green	0	2	7



Risk reduction to green: 5 risks have been assessed and the current risk category changed to Green (1.4 Trauma unit accreditation , 3.2a Engagement with external stake holders, 4.1a Delivery of income plan, 4.2a Halting divisional overspend and 4.2b Quality of management information). Of note Trauma Unit Status was achieved and there is significant positive assurance around engagement with external stakeholders.

Risk reduction to amber and within amber: Throughout the year there has been significant changes to the risks that are currently recorded as amber. Of note 5 risks initially identified as red using the Trust's risk management system have had new controls implemented and assurances highlighted such that the current risk has been reduced to amber. A further 8 risks that started as high ambers have been reduced to low ambers.

5. Recommendation

The Board is asked to note the updated BAF as presented and consider the following discussion point.

- Are these risks descriptions appropriate and does the Board agree with the assurances for each risk as presented?

The BAF will be updated in April to focus on changes to Trust objectives and any new/changing significant risks identified.

Colin Pink
Acting Head of Integrated Governance and Quality
March 2013

Surrey and Sussex Healthcare NHS Trust Board Assurance Framework 2012/13

Prepared for March 2013 Board meeting

Priority ID	Description of potential significant risk to Priority	Director responsible	Initial Risk Rating: Severity x Likelihood	Controls in place (to manage the risk)	Gaps in Control	Potential Sources of Assurance (documented evidence of controls effectiveness)	Actual Assurances: Positive (+) or Negative (-)	Assurance Level gained: RAG	Gaps in Assurances	Current Risk Rating: Severity x Likelihood	Mitigating actions underway	Progress against mitigation (including dates, notes on slippage or controls/ assurance failing	Action updated: date and by whom	Next update due	Target Risk Score	Date discussed at Board
Objective 1 - Deliver Safe, High Quality, Co-ordinated Care																
1.1. Achievement of national best practice in clinical care	1.1a Failure to improve mortality, particularly NOF	Medical Director	**S5 x L2 =10**	1)Regular review of Dr Foster alerts 2)Regular review mortality rates and COPD in clinical services 3)Standardised mortality review process 4)Mortality group established (see link with Risk 1192, 1055)	1) Limited numbers of pathways linking Trust to external services	1) HSMR 93% 2) KPI stroke monitored 3) Discussions and actions taken at mortality review meetings 4)Full review of #NOF cases presented and monitored by MBQR	Positive (+) HSMR below 100 and better than predicted (+) Falling standardised mortality (+) Within expected mortality rate for stroke care Negative (-) Alert for Fractured Neck of Femur. (-) Access to specialist beds (-) Performance for 4 hour target to get all #NOF cases t		First report from Mortality group to SQC yet to be presented	**S4 x L2 = 8**	1)Healthcare of the elderly strategy 2)Considering attaching orthogeriatrics to Surgery ward rounds 3)Increasing Jnr Dr Support 4)Implement system of alerting orthopaedic wards when at arrival at ED 5)Strengthening respiratory Team Consultant post 6)Agreeing COPD pathways and reviewing enhancing quality programs	1)Review and report on effectiveness for SQC 2)Healthcare of the Elderly Strategy underway	DH 13/03/13	By March Board	**S5 x L1 = 5**	Discussed at Nov Board - will be discussed at Mar Board
	1.1b Failure to reduce non-elective demand	Chief Operating Officer	**S5 x L5 =25**	1)Revised ED arrivals process which provides senior decision making earlier in the attendance 2)Live 'To come In' lists available to view in all specialty wards to encourage active pull of patients from AMU to the correct specialty bed 3)Executive review and action arising from weekly ED dashboard review 4)Intentional Rounding in ED embedded to maintain safety 5)All patients reviewed daily at clinical operations meeting 6)Daily 8:30 management meeting in Ed to review previous 24 hrs and plan for day ahead agreed 7)Two hourly board rounds to ensure patient plans progress and delays are escalated 8)Rolling programme of implementation of 11 ambulatory care pathways- 5 complete; 3 due end of Dec, 3 end of March. 9)Increased Medihome Capacity	1) Currently running with 7 locum / agency middle grades and 1 consultant vacancy	1) Combined weekly Quality and Performance Dashboard for ED reporting on a combination of quality and safety standards and the ED national indicators reported to exec meeting weekly 2) Safety and Quality Committee dashboard 3) Performance Management Framework and reporting to Trust Board 4) RTM data on patient experience in all clinical areas 5) External stakeholder inspections 6) Daily 9am performance review meeting 7) Capacity sheets updated three times a day 8) Daily winter Sit Reps (Commenced November)	Positive (+) Sustained Medical outliers in SAU decreased since start of calender year (+) Sustained decrease in cancelled elective procedures (Dec 11) (+) Reduction of 12 hour breaches (sustained) (+) SHA external review provided positive assurance on safety and quality (+) Below 3.5% target agreed with DTOC consistently (+) >95% Weekly ED performance since April 2012 (+) Working with partners commisioners/parteners to expedite flow through hospital (Medihome and community beds) Negative (-) Quality indicators for time to assessment / treatment		Continue to displace surgical beds (rate dropped to <20 beds daily)	**S5 x L2 = 10**	1)Demand management plans with local health economy agreed but delay in all 4 major schemes starting 2)Phase 2 of ambulatory care pathway commenced (further 11 pathways) 3)As part of a wider patient flow work stream look to develop a reduction in length of stay program 4)Winter plan agreed and being adopted, including new escalation processes (ICT), winter plans circulated 5)Discharge project team to be established to review long stay patients	1)Reduction in demand/activity is not supported/indicated by data 2)Phase 2 pathways being implemented but yet to make significant impact on admissions, preventing creep but not reducing number	JCB 14/03/13	By March Board	**S5 x L2 = 10**	Discussed at Nov Board - will be discussed at Mar Board
	1.1c Failure to comply with regulator expectations	Chief Nurse	**S4 x L4 = 16**	1)Safety priorities approved, KPI's in place and reported to Safety and Quality Committee 2)Patient Experience Group in place 3)Mock CQC inspection programme 4)RTM and other patient experience information with local action planning 5)Divisional action plans in place addressing patient experience feedback (see link with Risk 844, 1167,1356,1366,1328)	1) Staff understanding of their responsibilities under the Care Quality Commission regulatory framework remains poor	1)CQC and external stakeholder inspection reports 2)Patient Experience feedback all sources 3)Organisational Patient Safety Incident Reports from the National Patient Safety Agency benchmarking the reporting rates and types of incidents 4)Quarterly internal incident reports 5)Internal Audit reports 6)Audits of nursing assessment and care plan tool 7)Patient experience reporting to Trust Board and Safety and Quality Committee. 8) Nursing audit framework includes Essence of Care Benchmarks 9)Division action planning following mock CQC inspections, surveys and clinical Friday working. 10)Nursing audit framework includes Essence of Care Benchmarks	Positive (+) CQC verbal feedback following two day inspection Feb 13, Compliant with outcomes 8 of the 16 outcomes reviewed (+) Registration status with CQC shows no concerns Negative (-) CQC Risk profile shows areas of concern (based on public information, anticipated that this will improve)		1)Process of review for Provider Compliance Assessments 2)Triangulated reporting Complaints, Risks and Audits	**S4 x L2 = 8**	1)implement PEAT action plan arising from most recent inspection 2)Continuing with the development and introduction of ED operational standards and the enhancing nursing skill mix and competency. 3)Review nursing documentation 4)Review provider compliance assessments 5)Review compliance monitoring system 6)Synbiotix monitoring system to be rolled out which provides real time access to clinical quality indicators	1)Recent PEAT results very encouraging 2)Nursing documentation reviewed updated and in place 3)Nursing documentation group functioning 4)PCA review commenced (9 of 16 in date) 5)Policy for monitoring CQC compliance in draft, procedure agreed in principal 6)Initial implementation planned for April 2013	05/03/13 SB	By March Board	**S4 x L2 = 8**	Discussed at Nov Board - will be discussed at Mar Board
	1.1d Failure to establish the nursing safety thermometer effectively	Chief Nurse	**S4 x L3 = 12**	1)Fully implemented Trust wide across ahead of target, 100% data submission in place (see link with Risk 1055)	1)New inclusion criteria published 02/11/12 (Labour ward and Theatres Recovery)	1)Reports available	Positive (+)All ward areas collecting data and uploaded (+)100% data submission			**S4 x L1 = 4**	1)Continue to monitor data submission	N/A	05/03/13 SB	By March Board	**S4 x L1 = 4**	Discussed at Nov Board - will be discussed at Mar Board
	1.1e Workforce not performing to required expectations at point of care	Chief Nurse	**S4 x L4 = 16**	1)RTM and other patient experience information with local action planning 2)Policies and procedures clarify staff responsibilities 3)Professional Registration requirements 4)Clinical effectiveness audit teams (Weekly audits) 5)Clear managerial and clinical structures in place with single point accountability through the Chiefs of Service 6)Divisional action plans in place addressing patient experience feedback (see link with Risk 1171 and 1170)	1)Multidisciplinary working practice on ward rounds and for discharge is not standardised and embedded across the Trust; 2)Continued reliance / high levels of temporary staff (agency) in key areas such as ED, AMU 3)Compliance with completing the audit programme varies across the divisions.	1)National Staff Survey measures of staff engagement / opinion on fairness of reporting / incident management. 2)Observatory and Safer Smarter Care data 3)Patient Experience feedback all sources 4)Vacancy rates and workforce information reported to Trust Board 5)Audits of nursing assessment and care plan tool 6)Benchmarked performance in EQ, Safer smarter nurs	Positive (+) CQC verbal feedback following inspection Feb 13, Compliant with 8 of the 16 outcomes reviewed (+) Recruitment and retention group meeting to drive and monitor recruitment (+) Appraisal rate improving across the Trust (+) 80 managers trained in appraisal (+) SHMI (+) Safer Smarter Care data shows improvements		1)Divisions are not consistently reporting evidence of change from learning. 2)Lack of audit or review of evidence of Locum/temporary staff competency and reporting of performance during shift/s.	**S4 x L2 = 8**	1)Ongoing implementation of a wide ranging action plan, as part of clinical effectiveness implementation plan for approval, to drive up compliance with clinical audit programme. Audit plan being monitored by the Safety and Quality Committee. 2)Education programme - Dementia 3)Recruitment Centre to assess level of competence 4)Recruitment centre	1)Clinical effectiveness audits in place 2)Dementia programme commencing 3)Recruitment centre running weekly since November 12	05/03/13 SB	By March Board	**S4 x L2 = 8**	Discussed at Nov Board - will be discussed at Mar Board
	1.1f Failure to meet national targets to reduce HCAI	Medical Director	**S5 x L4 = 20**	1)IPCAS Group Team and group in place 2)Weekly taskforce in place 3)Infection control manual in place and information resources available 4)Antibiotic policy and guidelines in place 5) Infection control quality round implemented 6)Education for Jnr Doctors on induction 7)New cleaning products in use (Tristel, effective against C. diff spores) 8)Develop pocket size antimicrobial guide 9)Consultant led RCA and presentation of HCAI (MRSA, MSSA, CDI and hip and knee op	1)Antimicrobial prescribing compliance is low in areas 2)Risk assessment of patients with diarrhoea is not consistent, in particular on admission and at first onset 3)Variation in line care demonstrated by audit	1)KPI indicators 2)Reducing numbers of cases of C. diff year on year 3)No confirmed outbreaks of C. diff commenced during 2011/12 4)Recent PCT and SHA visits focusing on infection control 5)Recent CQC visit focusing on Nursing documentation and escalation	Positive (+)C. diff rate continues to drop year on year and on target (+)CQC visit Feb 2013 found no immediate concerns (+)Antimicrobial prescribing audit compliance (+)Actions taken as part of annual program (+) Recent CQC inspection highlighted improvements in MRSA screening (+)PCT visit inspecting controls and procedures Negative (-) MRSA BSI rate higher than acceptable		Extensive auditing and monitoring in place. Trust position known	**S5 x L2 = 10**	1)Launch diarrhoea risk assessment tool. 2)Consultants to lead on OSCE-based competency training for doctors on hand washing and insertion of invasive devices. 3) Further actions detailed in IPCAS annual plan 4)Update urinary catheter care policy carried out to be re-launched	1)Guides developed to be printed 3)Extensive scrutiny of annual plan of work monitored by IPCAS Group 4)Urinary catheter care plan re-launched	DH 13/03/13	By March Board	**S5 x L2 = 10**	Discussed at Nov Board - will be discussed at Mar Board
1.2. Ensure patients are cared for in the right place at the right time	1.2a Lack of ability to allocate the right bed first time in terms of respect and dignity.	Chief Nurse	**S4 x L3 = 12**	1) Operational meeting three times a day chaired by Chief / Deputy Chief Operating Officer with clinical involvement from Matrons, Nurse Specialists and therapists 2) Daily Board rounds by clinical site team 3) Live 'To come In' lists available to view in all specialty wards to encourage active pull of patients from AMU to the correct specialty bed	1)Levels of temporary staff (agency) in key areas such as ED, AMU 2)Additional workload for medical teams having to cover significant numbers of patients outside their bed base 3)The external influences outside of SASH control e.g.) demand management and delayed discharges in care	1)Patient Experience feedback all sources 2)Patient experience and complaints 3)Mixed sex breach data	Positive (+) Improved In-patient Survey results (Time to wait to be allocated a bed, privacy, treated with respect and dignity all improved) (+) Numbers of formal complaints are now significantly reduced (Patient Experience Group Report) (+) Empathica "Your Care Matters" provides qualitative assurance (+) Improved patient opnion data Negative (-) Patient Choices data (-) Complaints and incident data		SQC comparison of PT journeys indicated further development of process of right bed first time	**S4 x L2 = 8**	1)Ambulatory care pathways 2)Linked to 1.1b 3)Additional screens arriving to reduce chance of mixed sex accommodation breaches during winter pressures	See 1.1b	05/03/13 SB	By March Board	**S4 x L2 = 8**	Discussed at Nov Board - will be discussed at Mar Board

Surrey and Sussex Healthcare NHS Trust Board Assurance Framework 2012/13

Prepared for March 2013 Board meeting

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1.3 Safety and Experience of Patients in ED	1.3 Failure to ensure substantive workforce in ED with experience and skill	Chief Operating officer	**S5 x L5 =25**	1)Clinical Lead appointed 2)All consultant vacancies appointed 3)Middle grade rota filled (see link with Risk 553, 1192, 1055)	1)Further work required with SECAMB to improve hand over process 2)Embed "See and Treat" model and arrivals streaming 3)ED to Speciality referral pathways need to be adhered to	1)ED Medical Rota's 2)Breach analysis of senior decision making	Positive (+) Trauma Accreditation (+)Substantive medical workforce in ED (Rotas) (+)Clinical lead in post Negative (-)Evidence demonstrates inability to consistently achiev		Inability to process trauma unit status skill mix	**S5 x L1 = 5**	1) Recruitment agency unit engaged to support recruitment process 2) Review on site facility for primary care out of hours	Consultant and mid grade interviews in July, potentially strong candidates Complete	JCB14/03/13	By March Board	**S5 x L1 = 5**	Discussed at Nov Board - will be discussed at Mar Board
1.4. Develop clinical partnerships/Trust Status that provide safe and sustainable clinical services	1.4a Inability to comply with trauma unit accreditation	Medical Director	**S5 x L3 = 15**	1)Trauma steering group 2)Critical care network 3)Joint working with BSUH 4)Weekly project meetings		1) Minutes of Trauma steering group, MBQR and Critical Care Network	Positive (+)Trauma unit accreditation obtained (+)Recruited consultant with trauma leadership background (+)Mid grade vacancies being filled (+)Surgical lead for Trauma identified (+)TARN data now collected		Cancellation of meetings and gaps in essential data No independent mechanism for mapping/monitoring progress	**S5 x L1 = 5**	1)MD progress reports to Board 2)Recruitment of vacancies 3)Commence systems for gathering and generating necessary evidence to support accreditation	1)Trauma steering group work 2)Vacancies filled and appropriate skill mix achieved 3)TARN data collection established	CP 13/03/13	By March Board	**S5 x L1 = 5**	Discussed at Nov Board - will be discussed at Mar Board
Objective 2 - Ensure Patients are cared for and cared about																
2.1. Be recommended on the basis of "customer care"	2.1a Inability to improve patients' perceptions of services, staff or hospital	Chief Executive	**S4 x L4 =16**	1)Patient experience group 2)Communication team and work plans 3)Communications strategy 4)Complaints team 5)PALS team 6)Newly opened "Boots" effecting delayed discharge and outpatients' experience (See link 969, 1075, 1141,1256,1306,1364, 1405)	Need to encourage patients to provide both negative and positive comment in order for Trust to learn from experience	1) NHS Choices 2)Complaints feed back 3)Links feedback 4)Patients Council 5)HASC minutes 6)RTM	Positive (+)Recent update of inpatient survey (+)DoH KPI indicate that Trust is performing (+)RTM data (+)Compliments (+)PALs annual report (+)Excellent July PEAT report (+)Recent reduction in numbers of received complaints per month Negative (-)NHS Choices		Aggregated pt feedback report including RTM, PALS, complaints etc	**S4 x L2 = 8**	1)Preparation and Delivery of Customer Care Strategy 2)Senior leadership training and meetings 3)Extensive refurbishment of high pt flow areas	1)Customer Care training rolled out across Trust 3)Major refurbishment work completed, main entrance and ED, work to reduce escalation areas delivered on schedule 4 2)"Your care matters" implementation with extension to other areas 4) Patient experience feedback from Friends & Family Test 5) Feedback on Patient Opinion	GFM 8.3.13	By March Board	**S4 x L2 = 8**	Discussed at Nov Board - will be discussed at Mar Board
	2.1b Failure to maintain effective complaints management across the Trust	Chief Nurse	**S3 x L3 = 9**	1)Trust wide monitoring system 2)Divisional responsibility for actioning complaints investigation	1)Delays in administration of complaints, including signature and final editing 2)Central function yet to embed following change in workforce	1) Quarterly complaints reports 2) Compliance with completion on time and numbers of case reopened	Positive (+) Number of new complaints significantly lower than last year (+) Low numbers of cases referred to the Ombudsman Negative (-) Numbers of cases reopened (-) Performance in closing complaints (-) Supporting corporate function establishment		1)Performance data that details where a compliant is being held up in the system 2)Issues highlighted in Internal Audit regarding corporate reporting and analysis	**S4 x L2 = 8**	1)Reviewing supporting corporate function 2)Review working arrangements between Corporate body and Divisions to stream line the process 3)Review complaints policy to ensure it is fit for purpose and is aligned with new structures	1)Corporate function review commenced, joint working with PALs in place, corporate team restructure underway 2)Initial meetings held and regular focussed communication planned 3)Review of policy commenced October 2012	05/03/13 SB	By March Board	**S3 x L2 = 6**	Discussed at Nov Board - will be discussed at Mar Board
2.2. Treat all patients and their family/carers with Compassion, Courtesy and Privacy and Dignity	2.2a Failure to continually improve the patients perceptions of our staff	Chief Nurse	**S4 x L3 = 12**	1)Patient Experience Group in place 2)Leadership programmes in place at senior management level 3)Mock CQC inspection programme 4)RTM available at point of care 5)Divisional action plans in place addressing patient experience feedback 6)Nursing Clinical Effectiveness weekly audits commenced 7)Additional screens ordered to reduce likelihood of mixed sex accommodation breaches during winter pressures (see link with Risk 979)	1)The external influences outside of SASH control e.g. demand management and delayed discharges in care 2)Additional workload for medical teams having to cover significant numbers of patients outside their bed base	1)RTM data available and monitored by SQC and patient experience group 2)CEQUIN data 3)All sources of patient feedback, internal and external	Positive (+) CQC verbal feedback following two day inspection Feb 13, Compliant with outcomes 8 of the 16 outcomes reviewed (+) "Your Care Matters" feedback (+) CEQUIN patient experience (+) CQC feedback for complaints system (+) NHS Choices positive feedback (+) Improved inpatient survey results demonstrating improvments in treating patients with dignity (+) Improving numbers of patient complaints Negative		1) Pro actively encourage patients to use NHS choices PALs and complaints systems to improve information resources	**S4 x L2 = 8**	1) Customer care training 2) Trust overall compliance monitoring of the appraisals system 3) Roll out of Sit and See programme	1)Customer Care Training commenced 2)HR and Divisions monitoring appraisals 3)Early stages of "Sit and See" programme implemented	05/03/13 SB	By March Board	**S2 x L3 = 6**	Discussed at Nov Board - will be discussed at Mar Board
Objective 3 - Work in partnership with our community																
3.1. Work with our patients and partners to develop services that meet the needs of our community	3.1a Inability to develop and deliver cross - organisational services/pathways that meet patients' needs	Chief Operating Officer	**S4 x L5 = 20**	1) Ambulatory path ways rolled out 2) Caterham Dene and Crawley Clinical Assessment services established 3)Twice weekly whole system conference calls to proactively manage patient discharge	1)Gaps in assumptions made between PCT and CCGs 2)Whole system action needs more operational detail/time frames and deliverable outcomes	1)Internal activity data 2)Daily SIT reps 3)SECAMB activity data	Positive assurance (+): (+) Working with CCGs proactively to develop patient flow and plans to reduce non-elective demand (+)Feedback from CCGs and NHS Sussex regarding management of winter pressures (+)System management unscheduled care dashboard improving cases (+) 4 work programmes agreed to reduce unscheduled admissions Negative assurance (-): (-) Dual handover data with SECAMB (-) All 4 work programmes delayed		1) Triangulation of data at sufficient level to demonstrate transfer of activity vs. new activity	**S2 x L5 = 10**	1) Planned work to identify gaps in provision 2) Re focus of System Management Team group to operational delivery group 3) Agreed work stream set of KPI's and dashboard to inform SMT	1) Recognition that current plan is not fully delivering and is therefore refocusing on capacity elements of plan	JCB 14/03/13	By March Board	**S2 x L5 = 10**	Discussed at Nov Board - will be discussed at Mar Board
	3.1b Lack of strategic approach to identifying and developing opportunities (see 1.1b and 3.1a)	Chief Executive	**S4 x L3 = 12**	1)Transformation board in place, monitoring action plan 2)Clinical cabinet meeting between Trust Clinicians and CCGs 3)TFA Board 4)Increased Medihome Capacity and purchased community beds to improve patient flow	1)Rapid progress and changing in local care environment (Elective and Non elective activity) makes long term planning and forecast of activity difficult	1)Partcipationa with CCGS in developing new contracts and maintain activity 2)Kings Fund Work steam	Positive assurance: (+)Local commitment for extensive refurbishment of estate demonstrating key links with stakeholders (+)Repatriation of Chemotherapy services (+)High level conversations with other providers for maternity services (+)Positive feedback received for draft Clinical Strategy (+)Investment and Workforce committee discussion re partnership opportunities (+)Working with CCGs proactively to develop patient flow and plans to reduce non-elective demand (+)Feedback from CCGs and NHS Sussed relationships		1)Complexity of business model re chemotherapy (Funding)	**S4 x L3 = 8**	1)Clinical Strategy to be further developed 2)Drafting Integrated Business Plan to be developed 3)Working with Sussex on proactive care model (Frail Elderly Strategy)	1)Clinical Clinical Strategy developed and shared with SHA and CCGs 2)Draft IBP developed and shared with SHA and CCGs	CP 13/03/13	By March Board	**S4 x L2 = 8**	Discussed at Nov Board - will be discussed at Mar Board
3.2. Improve the way all other partners perceive and talk about SASH	3.2a Failure to effectively engage external stake holders	Chief Executive	**S4 x L2 = 8**	1)Stakeholder meetings and actions underway, such as HASC, LINKS, Patients Council and CQPM 2)GP Newsletter and GP forum	1)Evidence to demonstrate board to ward understanding of need to engage with stakeholders	1)HASC minutes 2)CQPM minutes 3)Patient focus groups 4)Peer review 5)RTM	Positive (+)Performing Trust on DoH KPI (+)Senior stakeholder acknowledgement that quality of care at SASH is improving (CEO of NHS SOE, CQC Inspector) (+)Attendance of stakeholders at focus groups and Trust committee meetings (+) Press and media coverage (+)Maternity services liaison committee (MSLC) Negative (-) Press and media coverage			**S3 x L2 = 6**	1)Develop and implement PPI Plan 2)Plan to embed experience based design into service provision and development 3)Proactively seeking and promoting positive news stories	1)PPI plan under development 2) Implementation of "Your Care Matters" Pilot with extension across the Trust 3) Regular positive news stories in local media 4) FT Project board with good partnership & stakeholder representation	GFM 8.3.13	By March Board	**S3 x L2 = 6**	Discussed at Nov Board - will be discussed at Mar Board

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Objective 4 - Become a Sustainable, Effective Organisation																
4.1.Live within our means both in year and ensure sustainability into the future	4.1a Failure to deliver income plan	Chief Financial Officer	**S5 x L3 = 15**	1) Business Plans and budgets (activity and financial) savings / transformation plans 2) Signed contract with commissioners. 3) Contract management process in place	1) NHS Sussex activity plan not fully profiled and aligned with Trust plans at Oct 2012 2) Although recovery plans are being developed with Sussex, there is a lack of clear change plans available at October 2012 3) At M06 activity levels remain within the previous trend providing significant pressure. 4) Contract management meetings and process are not running as they should. 5) Substantial contractual challenges are being made by CCGs	1) Financial performance quality and contractual reporting to Management Board and Trust Board (including CQUIN reporting process). 2) Performance Review process with Divisions, monthly contract cycle with PCTs (including clinical quality review where SASH Directors account for performance). Service line reporting process 3) Outputs and reporting from contract and information teams 4) Output and reporting from health system management (e.g.: System Management Team meeting) 5) Output of Contract Management Process (but please note issues there)	Positive assurance (+): (+) We have signed a full year settlement that covers Trust costs completely in 2012/13.		None: memoranda of understanding signed for both CCG areas that are binding and adequate for audit confirmation.	**S5 x L1 = 5**	No mitigating actions - final position is better than target risk.	Actions proceeding to timetable	PS 22/02/13	By March Board	**S4 x L2 = 8**	Discussed at Nov Board - will be discussed at Mar Board
	4.1b Failure to stop divisional overspending against budget	Chief Financial Officer	**S5 x L3 = 15**	1) Business Plans and budgets (activity and financial) savings / transformation plans 2) Divisional activity plans agreed & signed off 3) Additional activity budget being allocated after agreement of specific pressures 4) Internal Performance Review process	1) Nursing spend and medical agency spend controls subject to review and action. 2) Activity driven spend, notably in theatres, is having an adverse impact [In both areas action is in place and there are signs of it being effective]	1) Financial performance quality and contractual reporting to Management Board and Trust Board (including CQUIN reporting process). 2) Performance Review process with Divisions, monthly contract cycle with PCTs (including clinical quality review where SASH Directors account for performance). Service line reporting process 3) Outputs and reporting from contract and information teams 4) Output in financial reporting describes improvement and risk mitigation. Linkage between activity levels and spend is clear (notably in the Surgical Division with 18 week driver)	Positive assurance (+): (+) Overall forecast I&E position is balanced - income covers spend, and income is assured through MoU (see above). (+) All Divisions have budget control totals. At M10 they are within those targets, and indeed may not overspend as much as agreed.		None: see above - costs are covered by income agreement	**S3 x L2 = 6**	Risk contingency is included in the budget - at M10 the Trust is well within its limits.	Actions proceeding to timetable.	PS 22/02/13	By March Board	**S3 x L2 = 6**	Discussed at Nov Board - will be discussed at Mar Board
	4.1c Unable to provide realistic medium term financial plan	Chief Financial Officer	**S5 x L3 = 15**	1) Items referred to in 4.1c above 2) FIRST draft long term financial model and integrated business plan completed (submitted to SHA on 18 October)	None	1. Delivery of current year financial plans 2. Delivery of long term financial model and integrated business plan	Positive assurance (+) (+) Long term financial model provides realistic plan and scenarios describe wider robustness against downsides (+) Plan requires delivery of performance in 2012/13 - as described above that performance is going to be delivered (+) External approval has been informally received about proceeding following resolution of 2012/13 position and after meeting with SHA before Xmas. The LTFM has passed muster in this process although it has not been subject to full challenge and scrutiny. Negative assurance (-): (+) Savings and income levels in future years provide extremely challenging targets and the LTFM assumptions are subject to change dependent on CCG plans (+) Lack of clarity over commissioning plans for 2013/14 and future years Overall, on basis of current assumptions and delivery of		A) 2013/14 planning round not complete B) Further testing of LTFM	**S5 x L3 = 15**	1) Actions expected to move to more refined version of LTFM once commissioning plans for 2013/14 received and business planning complete (April 2013) Risk left red because of position in 2013/14 commissioning round.	Actions proceeding to timetable	PS 22/02/13	By March Board	**S4 x L2 = 8**	Discussed at Nov Board - will be discussed at Mar Board
	4.1d Liquidity: Inability to pay creditors / staff resulting from insufficient cash due to poor liquid position	Chief Financial Officer	**S5 x L5 = 25**	1. Bi weekly review of forward cash flow by finance team and CFO 2. Cash and working capital policy and strategy 3. Annual cash plan linked to business plan and capital plan (see link with Risk 1134)	None	1. Twice monthly reporting to CFO by finance team, SBS reporting on bank balance 2. Monthly finance reporting to Management Board and Trust Board	Positive assurance (+) Positive cash flow reported for every month in 2011/2012, and into 2012/13 (+) Liquid ratio has followed expectations (+) Cash flow forecast for year is OK, and now assured after income agreement. Negative assurance (+) no confirmed additional cash to resolve underlying liquidity problem Assurance RAG "amber" - no current cash problem but underlying problem unresolved.		In terms of cash flow management to end year, no material gaps in assurance. In terms of resolving the actual risk (liquidity), there is no confirmation of additional cash to resolve SoFP weakness.	**S5 x L3 = 15**	1) Day to day cash control is main action currently, which is straightforward for the rest of 2012/13 - things will alter depending on income agreements for 2013/14 2) Scenarios for cash control at end of 2012/13 being modelled ahead of finalisation of 2013/14 contract with CCGs. 3) Long term financial model now provides additional validation of the level of cash injection required and the interaction from an improving financial position within the model	Actions proceeding to timetable	PS 22/02/13	By March Board	**S4 x L3 = 12**	Discussed at Nov Board - will be discussed at Mar Board
4.2. Delivery of TFA and Monitor standards	4.2a Failure to Implement a governance framework suitable for foundation trust status	Director of Corporate Affairs	**S4 x L3 = 12**	1)BGAF assessment carried and action plan developed 2)Corporate governance framework 3)Interim Director of Corporate Affairs in post, vacancy filled	1)Corporate Governance infrastructure and support not yet clearly identified	1)BGAF assessment	Positive (+) Director of Corporate Affairs in post (+) Met current SHA TFA and all of SOM milestones (+)TDA visit planned for early April 2013		Gasp in evidence of implementation	**S4 x L2 = 8**	1) Detailed BGAF action plan developed and currently under review 2) Board Development Programme 3) FT Project Timeline 4) Draft Membership Strategy 5) Establishment of FT Project Board 6) Draft TFA	1) BGAF action plan has been discussed regularly at TB Seminars and progress against action plan monitored 2) Plans are being driven forward by Director of Corporate Affairs 3) Current TFA and SOM milestones have been delivered 4) Draft TFA due for discussion with TDA 5) FT Programme Manager post being recruited to	GFM 8.3.13	By March Board	**S4 x L2 = 8**	Discussed at Nov Board - will be discussed at Mar Board
	4.2b Unreliable information resulting in poor decision making	Director of Information and Facilities	**S4 x L3 = 12**	1) Data Quality Strategy written by Director of Information and Facilities and managed on everyday basis by Data Quality Manager reporting to Head of Information 2) Data Quality Report reviewed by Information Governance Meeting on a regular basis 3) Information used within wide range of Board and Management Reports 4) DQ Training key element of EPR/PAS Training 5) Performance meetings provide scrutiny	1) Insufficient DQ Resource to fully check all relevant KPIs	1) Monthly Data Quality Report as reviewed by Information Governance Group 2) Internal Audit Reports 3) External Audit Reports	Positive (+) Data quality report showing positive results (+) Internal audit report (+) Information Governance report (+) Feedback from PCT challenges of readmission rates (+) Increased Trust income following improvements in data quality (+) Performance review process developed with Divisions (+) Quality of IPQR report to board Negative (-) Quality of medical records effects quality of coding		None	**S2 x L3 = 6**	1) Development of rolling data quality programme looking at each KPI in turn (focussing on the BAF) 2) Data Quality Mark to be added to Performance Report based on above 3)Review function and quality of data quality team	1) Implementing a system for identifying data quality of KPI 2)BAF and KPIs to be reviewed in April 2013 to design data quality indicators for each metric etc 3) Increase capacity of Data Quality team, interviewing DQ clerks x2	CK 08/03/13	By March Board	**S4 x L2 = 8**	Discussed at Nov Board - will be discussed at Mar Board

Surrey and Sussex Healthcare NHS Trust Board Assurance Framework 2012/13

Prepared for March 2013 Board meeting

Priority ID	Description of potential significant risk to Priority	Director responsible	Initial Risk Rating: Severity x Likelihood	Controls in place (to manage the risk)	Gaps in Control	Potential Sources of Assurance (documented evidence of controls effectiveness)	Actual Assurances: Positive (+) or Negative (-)	Assurance Level gained: RAG	Gaps in Assurances	Current Risk Rating: Severity x Likelihood	Mitigating actions underway	Progress against mitigation (including dates, notes on slippage or controls/ assurance failings	Action updated: date and by whom	Next update due	Target Risk Score	Date discussed at Board
4.3. Listen to, value and develop our workforce	4.3a Ineffective staff development means that the Trust does not have the skilled workforce to deliver current and future services	Director of Human Resources	S4 x L3 = 12	1) Ratified Workforce Strategy and Plan 2) Training plan aligned to national and regional requirements 3) Appraisal and PDP compliance monitoring and reporting to Board (see link with Risk 910) 4) Statutory and mandatory training matrix (see link with Risk 1170). 5) Data collection and monitoring linked to ESR , and exception reporting	1) Quality of appraisals and personal development plans 2)Matrix requires ongoing review 3) Limited availability of training rooms 4) Trainer capacity 5)Quality of data received	1) Implementation Plan report to Investment and Workforce Committee SHA assurance process 2) Delivery of plan and monitoring of external training budgets (CPD Delivery plan and reporting) 3) Monthly performance reports to Management Board. 4) Annual Staff Survey responses to training questions. 5) Complementing current provision with e-learning programme. 6) Matrix reviewed and information governance included in programme from end October 12.	Positive (+) Implementing actions from Trust Workforce Strategy Plan 2012-2015 (+) LDA signed, SHA allocations received and SHA reporting quarterly (+) at least 20% mandatory and statutory training via e-learning (+) improvement in staff and patient survey results. (+) Performance Scorecared shows increase in statutory and mandatory compliance (+) Saving plans agreed (+) Recent staff survey shows improve in levels of motivation Negative		1) Inability to deliver e-learning project on time 2) Insufficient resources to fund Training needs 3) Lack of staff engagement and low morale 4) Poor appraisal compliance	S4 x L3 = 12	1) ongoing review and monitoring of Statutory and mandatory training matrix 2) continued delivery of revised Statutory and mandatory Training programme 3) More local delivery of statutory and mandatory training 4) New method of collecting appraisal data in place, monthly reports to Divisions on outstanding appraisals that month 5) Monitoring of appraisals by division at performance meetings 6) IT and network system difficulties escalated to Ian Mackenzie and Yvonne Parker; resource implications. 7)Leadership programs commenced (cohorts have already passed through the program) 8)Ward Managers Development program commenced	1) Review of matrix completed IG added from Oct 12. Matrix to be further reviewed at end of UK Skills for Health consultation on delivery of Core mandatory training with input from Education & Training Governance and Strategic Group. Streamline programme will reduce matrix to 10 core programmes with rest delivered locally. Staff coming from other NHS organisations will be able to 'passport' their training to SASH. 2) Revised programme being delivered 3) cascade training in place 4)& 5) New appraisal reporting method in place. 6) capital bid made.	30/01/2013 BC/JM	By March Board	S4 x L2 = 8	Discussed at Nov Board - will be discussed at Mar Board
	4.3b Ineffective staff engagement and buy-in of staff to the Trusts objectives and direction delays or derails service and workforce redesign and ability to make financial savings	Director of Human Resources	S4 x L3 = 12	1) Staff Survey engagement score 2) NHS Employers Engagement Framework adopted 2012, Staff Engagement OD plan developed 2012, reporting directly to Trust Board (see link with Risk 1321) 3) Focus groups and in year temperature check on engagement 4) Team briefing mechanism for message cascade 5) Transformation Plans embedded in business planning cycle. 6) Sash Window magazine for staff, Health Focus magazine for community. 7) Star of the Month, Team awards and annual staff awards evening. 8)Wellbeing agenda and activities. 9) Staff suggestion box	Lag between Staff survey completion and results - being addressed through in year temperature check and focus groups. 2012 staff survey results are being released one month earlier than previously	1) Annual Board report on staff survey results and action plan 2) Staff will be involved in its development - Engagement OD Strategy approved by Board in 2012. 3) Report to Executive Management Board on results 4) Number of briefings held during 12/13 and attendance sheets 5) PMO monitoring, monthly reports to Management Board	(+)Attendance at team briefs and Senior Leaders Meeting (+) Board Report in May (+)Customer Care Pilot launch in June. Frontline staff engaged in design and development (+)Assurance at Investment and Workforce Committee on internal comms strategy (+)Improved feedback from internal communications approach (-) Feedback sessions ESH and Crawley Hospital		1) Engagement score improved in 2012 staff survey, now average for acute Trusts, requires long tem action and commitment to maintain improvements	S4 x L2 = 8	1) Equality and Diversity & HR Steering Group 2) Board Seminar engagement 3) Focus Groups for Engagement Strategy. 4) Engagement OD plan approved by Board 2012 and monitored six monthly	actions agreed to progress	30/01/2013 SK/JM	By March Board	S4 x L2 = 8	Discussed at Nov Board - will be discussed at Mar Board
	4.3c Lack of leadership capacity and capability to engage with and develop staff delays or derails workforce redesign and ability to make financial savings	Director of Human Resources	S3 x L3 = 9	1) Leadership programmes provides a cohort of 150 senior managers to effect change. Programmes of change focused on trust priorities. 2) Training needs analysis annually and funding of external training through the bursary 3) Clear managerial and clinical structures with single point accountability through the Chiefs of Service. 4) Investment and Workforce Committee oversight of Training Plan 5) Board development programme		1) Attendance at leadership training and output of change project 2) Delivery of plan and monitoring of external training budgets 3) Performance management processes from ward to board, vacancies in management structures 4) Reports being received at Investment and Workforce committee 5) Completion of programme	(+) 200 Senior Leaders trained under Healthskills with different work streams over 2 years (+) 1st Cohort Leadership in Action programme has completed, 2nd cohort completed (+) Essentials of Management pilot completed, programme roll out from March 2013 following second evaluation (+) 2012-2013 Training Plan in place. (+) LDA signed and SHA allocations received and Bursary panels in session (+) New clinical structure in place with Chiefs of Staff (+) Regular Board seminars, recent Board meeting and observation by Healthskills (+) LEAP leadership Programme by KSS Deanery for Medical teaching Faculty, 2nd programme completed 9/11/12 (+) Chiefs and Clinical leads Development Sessions - rolling programme established (+) Board Development review in progress with Dir of Corp Affairs		1) How to measure leadership training - identifying link between leadership activities and programmes and organisational change 2) Lack of behavioural change. 3) Essentials of Management rollout on hold until April du to service pressures.	S2 x L4 = 8	1) Establish framework to enable short-term change or KPI measures to show added value of programmes, new structures and processes in place 2) Attendance at Senior Leaders meeting and engagement with Transformation Plans 3) Prioritising TNA funding to Trust priorities	1) Monitor through Management Board for Performance 2) New Performance Score card measuring quality, patient satisfaction, staff satisfaction and performance	30/01/2013 BC/JM	By March Board	S2 x L4 = 8	Discussed at Nov Board - will be discussed at Mar Board